FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027870

Facility Name: ST. AGNES MANOR, INC.

Address: 1721 SOUTH WABASH (Number) CHICACO (City) 60616 (Zip Code)

County: COOK

Telephone Number: (312) 787-9400 **Fax #** (312) 787-9590

IDPA ID Number: 36-3192742

Date of Initial License for Current Owners: 7/26/1983

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) JEFFREY K. SINGER, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,586	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,516	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	72,102	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	51,513	3,600	5,716	60,829	8
9	SNF/PED					9
10	ICF	4,860	13		4,873	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,373	3,613	5,716	65,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.12%

D. How many bed-hold days during this year were paid by Public Aid? 358 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/01/1983

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1983 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 4,969

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary		36,385	377,677	414,062		414,062		414,062			1
2	Food Purchase		453,144		453,144	(50,523)	402,621	(248)	402,373			2
3	Housekeeping	19,022	49,114	270,757	338,893		338,893		338,893			3
4	Laundry		81,115	104,772	185,887		185,887		185,887			4
5	Heat and Other Utilities			175,186	175,186		175,186	1,268	176,454			5
6	Maintenance	41,547	144,785	221,013	407,345		407,345	(57,497)	349,848			6
7	Other (specify):*											7
8	**TOTAL General Services**	60,569	764,543	1,149,405	1,974,517	(50,523)	1,923,994	(56,477)	1,867,517			8
	B. Health Care and Programs											
9	Medical Director			2,073	2,073		2,073		2,073			9
10	Nursing and Medical Records	862,652	215,112	1,658,356	2,736,120		2,736,120	(14,775)	2,721,345			10
10a	Therapy	72,579	24,034		96,613		96,613	(3,124)	93,489			10a
11	Activities	191,696	15,225	42,841	249,762		249,762		249,762			11
12	Social Services	65,585		5,076	70,661		70,661	(216)	70,445			12
13	Nurse Aide Training											13
14	Program Transportation			713	713		713		713			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,192,512	254,371	1,709,059	3,155,942		3,155,942	(18,115)	3,137,827			16
	C. General Administration											
17	Administrative			480,000	480,000		480,000	(359,558)	120,442			17
18	Directors Fees											18
19	Professional Services			45,669	45,669	(3,579)	42,090	5,993	48,083			19
20	Dues, Fees, Subscriptions & Promotions			20,385	20,385		20,385	(7,277)	13,108			20
21	Clerical & General Office Expenses	71,923	29,329	139,655	240,907		240,907	89,175	330,082			21
22	Employee Benefits & Payroll Taxes			169,481	169,481	50,523	220,004		220,004			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,520	1,520		1,520		1,520			24
25	Other Admin. Staff Transportation			253	253		253	2,649	2,902			25
26	Insurance-Prop.Liab.Malpractice			100,230	100,230		100,230	1,223	101,453			26
27	Other (specify):*							29,140	29,140			27
28	**TOTAL General Administration**	71,923	29,329	957,193	1,058,445	46,944	1,105,389	(238,655)	866,734			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,325,004	1,048,243	3,815,657	6,188,904	(3,579)	6,185,325	(313,247)	5,872,078			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

ST. AGNES MANOR, INC.
0027870
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	50,523	
2	FOOD		50,523

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	3,579	
19	PROFESSIONAL FEES		3,579

To reclass cost of appealing real estate taxes

Facility Name & ID Number ST. AGNES MANOR, INC. #0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			128,847	128,847		128,847	82,391	211,238			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,767	17,767		17,767	141,400	159,167			32
33	Real Estate Taxes			228,804	228,804	3,579	232,383	5,656	238,039			33
34	Rent-Facility & Grounds			328,082	328,082		328,082	(328,082)				34
35	Rent-Equipment & Vehicles			9,663	9,663		9,663		9,663			35
36	Other (specify):*											36
37	**TOTAL Ownership**			713,163	713,163	3,579	716,742	(98,635)	618,107			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,549	193,436	375,985		375,985	(2,930)	373,055			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,346	4,346		4,346	(147)	4,199			41
42	Provider Participation Fee			108,154	108,154		108,154		108,154			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		182,549	305,936	488,485		488,485	(3,077)	485,408			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,325,004	1,230,792	4,834,756	7,390,552		7,390,552	(414,959)	6,975,593			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	46,838	30		9
10	Interest and Other Investment Income	(301)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(248)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,198)	21		18
19	Entertainment				19
20	Contributions	(1,750)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,620)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,253)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(74,218)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,750)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(369,209)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (369,209)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (414,959)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ST. AGNES MANOR, INC.

ID# 0027870

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	VENDING INCOME	(147)	41	2
3	COLLECTIONS	(218)	19	3
4	TRUST FEES	(620)	20	4
5	CORP ANNUAL FEE	(100)	20	5
6	PPA - RESPIRATORY SUPPLIES	(3,124)	10A	6
7	PPA - MEDICAL SUPPLIES PART A	(2,930)	39	7
8	PPA - NURSING SUPPLIES	(156)	10	8
9	PPA - REPAIRS AND MAINTENANCE	(798)	6	9
10	PPA - SOCIAL SERVICE CONSULTANTS	(216)	12	10
11	PPA - PROFESSIONAL FEES	(217)	19	11
12	CAPITLIZED REPAIRS AND MAINTENANCE	(65,692)	6	12
13				13
14				14
15				15
16				16
17				17
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85				85
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89				89
90	**Total**	(74,218)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(248)											(248)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,268									1,268	5
6	Maintenance	(66,490)		8,993									(57,497)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(66,738)		10,261									(56,477)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(156)						(14,619)					(14,775)	10
10a	Therapy	(3,124)											(3,124)	10a
11	Activities													11
12	Social Services	(216)											(216)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(3,496)						(14,619)					(18,115)	16
	C. General Administration													
17	Administrative			(480,000)	63,984	56,458							(359,558)	17
18	Directors Fees													18
19	Professional Services	(435)		5,295				1,133					5,993	19
20	Fees, Subscriptions & Promotions	(9,090)		1,813									(7,277)	20
21	Clerical & General Office Expenses	(9,451)		98,626									89,175	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			2,649									2,649	25
26	Insurance-Prop.Liab.Malpractice			1,223									1,223	26
27	Other (specify):*			17,193	6,980	4,967							29,140	27
28	**TOTAL General Administration**	(18,976)		(353,201)	70,964	61,425		1,133					(238,655)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(89,210)		(342,940)	70,964	61,425		(13,486)					(313,247)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	46,838	26,813	8,740									82,391	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(301)	109,773	31,928									141,400	32
33	Real Estate Taxes			5,656									5,656	33
34	Rent-Facility & Grounds		(328,082)										(328,082)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	46,537	(191,496)	46,324									(98,635)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(2,930)											(2,930)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(147)											(147)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(3,077)											(3,077)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,750)	(191,496)	(296,616)	70,964	61,425		(13,486)					(414,959)	45

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	60.00%	SEE ATTACHED		SEE ATTACHED		
DANIEL O'BRIEN	20.00%					
MARY O'BRIEN	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 328,082	1721 CORPORATION		$	$ (328,082)	1
2	V	32	INTEREST EXPENSE		1721 CORPORATION		109,773	109,773	2
3	V	30	DEPRECIATION		1721 CORPORATION		26,813	26,813	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 328,082			$ 136,586	$ * (191,496)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 1,268	$ 1,268	15
16	V	6	REPAIRS AND MAINT.		MADO MGMT. LP		8,993	8,993	16
17	V	19	PROFESSIONAL FEES		MADO MGMT. LP		5,295	5,295	17
18	V	20	DUES AND SUBSCRIPTIONS		MADO MGMT. LP		1,813	1,813	18
19	V	21	CLERICAL AND GENERAL		MADO MGMT. LP		98,626	98,626	19
20	V	25	AUTO EXPENSE		MADO MGMT. LP		2,649	2,649	20
21	V	26	PROPERTY INSURANCE		MADO MGMT. LP		1,223	1,223	21
22	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		17,193	17,193	22
23	V	30	DEPRECIATION		MADO MGMT. LP		8,740	8,740	23
24	V	32	INTEREST		MADO MGMT. LP		31,928	31,928	24
25	V	33	REAL ESTATE TAXES		MADO MGMT. LP		5,656	5,656	25
26	V	17	MANAGEMENT FEES	480,000	MADO MGMT. LP			(480,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 480,000			$ 183,384	$ * (296,616)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	$	MADO MGMT. LP	100.00%	$ 7,540	$ 7,540	15
16	V	27	EMP. BEN.-D. O'BRIEN		MADO MGMT. LP		2,596	2,596	16
17	V								17
18	V	17	SALARY-P. O'BRIEN		MADO MGMT. LP		33,333	33,333	18
19	V	27	EMP. BEN.-P. O'BRIEN		MADO MGMT. LP		2,397	2,397	19
20	V								20
21	V	17	SALARY-C. STUMPF		MADO MGMT. LP		23,111	23,111	21
22	V	27	EMP. BEN.-C. STUMPF		MADO MGMT. LP		1,987	1,987	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 70,964	$ * 70,964	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$	$	15
16	V	17	ADMINISTRATIVE SALARY		MADO MGMT. LP		56,458	56,458	16
17	V	21	CLERICAL SALARY		MADO MGMT. LP				17
18	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		4,967	4,967	18
19	V	30	DEPRECIATION-WAREHOUSE		MADO MGMT. LP				19
20	V	33	REAL ESTATE TAXES		MADO MGMT. LP				20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 61,425	$ * 61,425	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$ 85,005	WINDY CITY NURSING	100.00%	$ 85,005	$	15
16	V	10	NURSING	1,652,547	WINDY CITY NURSING		1,652,547		16
17	V	11	ACTIVITIES	40,906	WINDY CITY NURSING		40,906		17
18	V	21	OFFICE	110,442	WINDY CITY NURSING		110,442		18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,888,900			$ 1,888,900	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$ 157,172	ST. AGNES MEDICAL EQUIPMENT	100.00%	$ 142,553	$ (14,619)	15
16	V	19	PROFESSIONAL FEES		ST. AGNES MEDICAL EQUIPMENT		1,133	1,133	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 157,172			$ 143,686	$ * (13,486)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL O'BRIEN	General Partner	Administrative	20.00%	SEE ATTACHED	6	15.00	Alloc-Mado	$ 7,540	17-7	1
2	PETER O'BRIEN	General Partner	Administrative	60.00%	SEE ATTACHED	6	10.00	Alloc-Mado	33,333	17-7	2
3	CHARLES STUMPF	Relative	Administrative		SEE ATTACHED	8	17.77	Alloc-Mado	23,111	17-7	3
4	JAMES WEST	Relative	Clerical		SEE ATTACHED	10.8	27.00	Alloc-Mado	13,726	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 77,710		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	243,330	5	$ 4,695	$	65,702	$ 1,268	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	243,330	5	33,305		65,702	8,993	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	243,330	5	19,610		65,702	5,295	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	243,330	5	6,715		65,702	1,813	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	243,330	5	365,265	298,189	65,702	98,626	5
6	25	AUTO EXPENSE	PATIENT DAYS	243,330	5	9,811		65,702	2,649	6
7	26	PROPERTY INSURANCE	PATIENT DAYS	243,330	5	4,530		65,702	1,223	7
8	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	243,330	5	63,675		65,702	17,193	8
9	30	DEPRECIATION	PATIENT DAYS	243,330	5	32,369		65,702	8,740	9
10	32	INTEREST	PATIENT DAYS	243,330	5	118,247		65,702	31,928	10
11	33	REAL ESTATE TAXES	PATIENT DAYS	243,330	5	20,949		65,702	5,656	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 679,171	$ 298,189		$ 183,384	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	30,158	30,158	6	7,540	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	10,385		6	2,596	2
3										3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	250,000	250,000	6	33,333	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	17,978		6	2,397	5
6										6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	130,000	130,000	8	23,111	7
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	11,175		8	1,987	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 449,696	$ 410,158		$ 70,964	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	1,218				1
2	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	303,237	303,237		56,458	2
3	21	CLERICAL SALARY	DIRECT ALLOCATION		3	80,490	80,490			3
4	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	51,678			4,967	4
5	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1	1,082				5
6	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	1,865				6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 439,570	$ 383,727		$ 61,425	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WINDY CITY NURSING
Street Address: 1541 N. WELLS STREET
City / State / Zip Code: CHICAGO, IL 60610
Phone Number: (773) 787-6400
Fax Number: (773) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	DIRECT ALLOCATION			$	$		$ 85,005	1
2	10	NURSING	DIRECT ALLOCATION						1,652,547	2
3	11	ACTIVITIES	DIRECT ALLOCATION						40,906	3
4	21	OFFICE	DIRECT ALLOCATION						110,442	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,888,900	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ST. AGNES MEDICAL EQUIPMENT
Street Address: 1541 N. WELLS STREET
City / State / Zip Code: CHICAGO, IL 60610
Phone Number: (773) 787-9400
Fax Number: (773) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 143,553	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION						1,133	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 144,686	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DANIEL O'BRIEN	X		WORKING CAPITAL				5,207,422				6
7	NORTH COMMUNITY BANK		X	WORKING CAPITAL							14,994	7
8	TIFCO		X	INSURANCE FINANCING							2,773	8
9	TOTAL Facility Related						$	$ 5,207,422			$ 17,767	9
	B. Non-Facility Related*											
10	Supplemental Schedule							2,995,750			141,400	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 2,995,750			$ 141,400	14
15	TOTALS (line 9+line14)						$	$ 8,203,172			$ 159,167	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC-MADO	X					$	$			$ 31,928	1
2	EXCHANGE BANK		X	WORKING CAPITAL				8,000				2
3	BUILDING COMPANY	X		WORKING CAPITAL				2,987,750			109,773	3
4	INTEREST INCOME										(301)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 2,995,750			$ 141,400	21

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	260,088	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	244,140	2
3. Under or (over) accrual (line 2 minus line 1).	$	(15,948)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	250,408	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	3,579	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	238,039	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	238,256	8
	1996	245,628	9
	1997	231,157	10
	1998	245,703	11
	1999	240,677	12

CALCULATION OF ACCRUAL = 238484 X 1.05 = 250408

ALLOC MADO - 5656

ACCRUAL USED ON 1999 COST REPORT = PY COST REPORT + ADJUSTMENT TO ACCRUAL

257988 + 2100 = 260088

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,975 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	31,879		$ 75,250	1
2					2
3	TOTALS	31,879		$ 75,250	3

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	197		1983	1983	$ 424,750	$	35	$	$	$ 424,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1983	1,402,995	70,150	20	70,150		1,165,765	9
10	Various			1984	132,601	6,630	20	6,630		112,136	10
11	Various			1986	21,150		20			21,150	11
12	Various			1987	10,000	500	20	500		8,336	12
13	Various			1988	72,045	2,287	20	3,603	1,316	33,494	13
14	Various			1990	150,700	4,876	20	7,329	2,453	62,955	14
15	Various			1991	37,665	1,197	20	1,883	686	14,971	15
16	Various			1992	45,688	11	20	2,285	2,274	11,465	16
17	Various			1993	56,127	1,118	20	2,806	1,688	16,175	17
18	Various			1994	* 182,905	1,467	20	9,146	7,679	47,700	18
19	Various			1995	* 204,001	9,312	20	10,200	888	54,619	19
20	VENTILLATION			1996	2,650		20	133	133	610	20
21	METAL DOORS			1996	4,100		20	205	205	888	21
22	LEROY STEEL			1996	10,600		20	530	530	2,518	22
23	DRYWALL			1996	3,843	192	20	192		960	23
24											24
25	PAGE 12-1 REP TOTALS				83,271	2,906		2,852	(54)	16,388	25
26											26
27	PAGE 12I TOTALS				7,818	(1,775)		(1,594)	181	100	27
28	PAGE 12H TOTALS				84,594			3,023	3,023	3,023	28
29	PAGE 12G TOTALS				254,115			12,710	12,710	12,710	29
30	PAGE 12F TOTALS				56,208			2,811	2,811	2,811	30
31	PAGE 12E TOTALS				58,503	1,716		2,926	1,210	6,198	31
32	PAGE 12D TOTALS				208,030	10,238		10,403	165	26,240	32
33	PAGE 12C TOTALS				76,145	3,940		3,809	(131)	10,331	33
34	PAGE 12B TOTALS				181,593	9,056		9,031	(25)	32,710	34
35	PAGE 12A TOTALS				232,975	6,636		11,652	5,016	49,723	35
36	TOTAL (lines 4 thru 35)				$ 4,005,072	$ 130,457		$ 173,215	$ 42,758	$ 2,138,726	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CEMENT ON ANNEX			1996	14,550		20	728	728	3,215	9
10	CONCRETE GALLAGH			1996	5,000		20	250	250	1,167	10
11	TELEDYNE LAARS			1996	8,952	230	20	448	218	2,128	11
12	DOORS/FRAMES			1996	1,192	60	20	60		300	12
13	CARPET			1996	896	45	20	45		225	13
14	ELECTRICAL WORK			1996	2,078	104	20	104		520	14
15											15
16	SECURITY SYSTEM			1996	1,202	60	20	60		300	16
17	TABLES			1996	759	38	20	38		190	17
18	SEWER			1996	5,500	275	20	275		1,375	18
19	KELCO ELECTRIC			1996			20				19
20	FIRE FLASH TILES			1996	1,039	52	20	52		260	20
21	BOILER			1996	1,385	69	20	69		345	21
22	ANNEX			1996	76,398		20	3,820	3,820	17,508	22
23	POWER SUPPLY			1996	1,055	53	20	53		265	23
24	ELEVATOR REPAIRS			1996	7,500	375	20	375		1,875	24
25	IRON CAST SPOUT			1996	1,124	56	20	56		280	25
26	METAL DOORS			1996	950	48	20	48		240	26
27	REFRIGERANT LINES			1996	2,781	139	20	139		695	27
28	TILES			1996	5,810	291	20	291		1,455	28
29	ROOF REPAIRS			1996	16,100	805	20	805		4,025	29
30	PLYWOOD/FORMULAR			1996	3,770	189	20	189		945	30
31	TILES/PANELS/LINE			1996	1,537	77	20	77		385	31
32	STRUCTUAL STEEL WORK			1997	59,947	2,997	20	2,997		9,740	32
33	JOHN HARRIS-ROOF REP			1997	2,800	140	20	140		455	33
34	WALL REPAIRS			1997	5,000	250	20	250		792	34
35	FIRE DAMPERS			1997	5,650	283	20	283		1,038	35
36	TOTAL (lines 4 thru 35)				$ 232,975	$ 6,636		$ 11,652	$ 5,016	$ 49,723	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER REPAIRS			1997	8,100	405	20	405		1,620	9
10	CONCRETE FLOOR			1997	* 8,180	409	20	359	(50)	359	10
11	FIRE ALARM			1997	29,100	1,455	20	1,455		5,456	11
12	ELECTRICAL WORK			1997	36,400	1,820	20	1,820		7,280	12
13	WINDOW REPAIRS			1997	3,279	164	20	164		629	13
14	DOORS			1997	17,839	892	20	892		3,494	14
15	DOORS			1997	515	26	20	26		85	15
16	WINDOW REPAIRS			1997	2,150	108	20	108		351	16
17	DOORS			1997	4,544	227	20	227		719	17
18	IRON FENCE - LOT			1997	5,850	293	20	293		1,001	18
19	WINDOW REPAIRS			1997	9,500	475	20	475		1,544	19
20	CONCRETE REPAIRS			1997	9,800	490	20	490		1,797	20
21	ELEVATOR MOTOR			1997	9,800	490	20	490		1,960	21
22	MASONRY WORK			1997	5,000	250	20	250		875	22
23	4 MOTORS FOR A/C			1997	1,183	59	20	59		236	23
24	YALE SECURITY-SMOKE			1997	741	37	20	37		114	24
25	STRUCTUAL STEEL WORK			1997	12,496	625	20	625		2,188	25
26	EXIT SIGNS			1997	923	46	20	46		176	26
27	FENCE			1997	504		20	25	25	77	27
28	2 NEW DOOR RESTRICTO			1997	2,600	130	20	130		477	28
29	DOOR LOCKS			1997	927	46	20	46		173	29
30	KLECO - HOT WATER HT			1997	1,255	63	20	63		236	30
31	DATILE-TILE			1997	1,804	90	20	90		353	31
32	DRILL OPENING FOR DO			1997	850	43	20	43		154	32
33	WATER HEATER			1997	5,265	263	20	263		877	33
34	WINDOWS			1997	955	48	20	48		156	34
35	AMER OLEAN-TILES			1997	2,033	102	20	102		323	35
36	TOTAL (lines 4 thru 35)				$ 181,593	$ 9,056		$ 9,031	$ (25)	$ 32,710	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	10 INTERIOR DOORS			1997	756	38	20	38		117	9
10	CENTRAL AIR UNITS			1997	1,088	109	20	54	(55)	180	10
11	FIRE DAMPERS			1997	1,185	59	20	59		207	11
12	KITCHEN EXHAUST FANS			1997	1,313	66	20	66		220	12
13	4 BATHROOM PARTITION			1997	2,640	132	20	132		495	13
14	GAS LINE REPAIRS			1997	3,850	193	20	193		643	14
15	BOILER REPAIR			1998	1,080	54	20	54		162	15
16	PIPE REPAIR			1998	4,370	219	20	219		657	16
17	DOOR REPAIR			1998	1,450	73	20	73		219	17
18	Architect Fees			1998	3,031		20	152	152	317	18
19	HEATING			1998	1,025		20	51	51	132	19
20	BRONZE DOORS			1998	1,700	85	20	85		234	20
21	NURSE CALL SYSTEM			1998	7,003	437	20	350	(87)	1,115	21
22	DOOR REPAIR			1998	795	40	20	40		120	22
23	FIREGUARDS			1998	2,075	104	20	104		277	23
24	INDUCER MOTOR			1998	540	27	20	27		77	24
25	DOOR REPAIR			1998	864	43	20	43		129	25
26	NURSE CALL SYSTEM			1998	2,811	141	20	141		423	26
27	PLUMBING WORK			1998		192	20		(192)		27
28	AIR COMPRESSOR			1998	540	27	20	27		79	28
29	FIREGUARDS			1998	2,478	124	20	124		331	29
30	GATE INSTALLATION			1998	600	30	20	30		85	30
31	MOTOR			1998	560	28	20	28		70	31
32	HEATING UNIT			1998	23,485	1,174	20	1,174		2,739	32
33	SMOKE DETECTION SYST			1998	1,920	96	20	96		272	33
34	RAILS AND STAIRS			1998	8,000	400	20	400		900	34
35	DRAIN MAINTENANCE			1998	986	49	20	49		131	35
36	TOTAL (lines 4 thru 35)				$ 76,145	$ 3,940		$ 3,809	$ (131)	$ 10,331	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLASTERBOARD			1998	750	38	20	38		108	9
10	FIREGUARDS			1998	1,461	73	20	73		176	10
11	FLOOR FLANGE/TILES			1998	2,224	111	20	111		287	11
12	FIREGUARDS			1998	2,348	117	20	117		302	12
13	DOOR REPAIR			1998	874	44	20	44		92	13
14	GAS LINE			1998	1,708	85	20	85		177	14
15	PIPES			1998	2,665	133	20	133		288	15
16	DRYER EXHAUST			1998	2,500	125	20	125		281	16
17	6 MOTORS			1998	645	32	20	32		72	17
18	CEILING TILES			1998	2,751	138	20	138		322	18
19	ROOFTOP CHILLER			1998	1,225	61	20	61		142	19
20	SMOKE DAMPER			1998	2,770	139	20	139		382	20
21	A/C INSTALL			1998	16,275	814	20	814		1,967	21
22	H20 PROOF SEALER			1998	5,600	280	20	280		700	22
23	FAN COIL			1998	1,196	60	20	60		140	23
24	BUILDING WORK			1998	41,520	2,190	20	2,076	(114)	6,456	24
25	SPRINKLER SYSTEM			1998	7,390	370	20	370		1,018	25
26	SHEET METAL			1998	7,118	356	20	356		831	26
27	FIRE DAMPERS			1998	336	17	20	17		38	27
28	ROOFING			1998	3,550	178	20	178		445	28
29	FIRE GUARDS			1998	3,561	178	20	178		430	29
30	BRONZE DOORS			1998	6,300	315	20	315		683	30
31	FIREGUARDS			1998	2,216	111	20	111		305	31
32	ELEVATOR			1998	85,458	4,273	20	4,273		9,970	32
33	CARPENTRY WORK			1998			20				33
34	ROOF REPAIR			1998	1,600		20	80	80	180	34
35	Carpentry Work			1998	3,989		20	199	199	448	35
36	TOTAL (lines 4 thru 35)				$ 208,030	$ 10,238		$ 10,403	$ 165	$ 26,240	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpentry Work			1998			20				9
10	PAINTING			1998	607		20	30	30	30	10
11	PAINTING			1998	999		20	50	50	50	11
12	INSULATION			1998	3,650		20	183	183	503	12
13	PLASTERBOARD/STUDS			1998	4,217	211	20	211		615	13
14	FIRE GUARDS			1998	2,374	119	20	119		298	14
15	GRAVEL/LIMESTONE			1998	795	40	20	40		100	15
16	DOOR/A/C/GATE REPAIR			1998	1,162	58	20	58		145	16
17	BUILDING IMPROV			1998	21,923	1,096	20	1,096		3,014	17
18	SCAFFOLDING			1998	3,844	192	20	192		496	18
19	TILES CEILING			1999	1,234		20	62	62	62	19
20	PANEL AT LAUNDRY RM			1999	1,102		20	55	55	55	20
21	PLASTER BOARD			1999	1,163		20	58	58	58	21
22	PLASTER BOARD			1999	2,440		20	122	122	122	22
23	KRAFT INSULATION			1999	1,916		20	96	96	96	23
24	LIGHTING SUPPLIES			1999	1,309		20	65	65	65	24
25	REPAIR WORK			1999	1,000		20	50	50	50	25
26	LOBBY LEVELING			1999	1,480		20	74	74	74	26
27	LIGHTING SUPPLIES			1999	618		20	31	31	31	27
28	BLINDS			1999	2,352		20	118	118	118	28
29	ELEVATOR FRAMES			1999	545		20	27	27	27	29
30	ELEVATOR REPAIRS			1999	553		20	28	28	28	30
31	ELECTRICAL SUPPLIES			1999	608		20	30	30	30	31
32	(8) 4SP MOTORS			1999	628		20	31	31	31	32
33	TILES/ELECTRICAL			1999	719		20	36	36	36	33
34	GENERATOR REPAIRS			1999	675		20	34	34	34	34
35	ELECTRICAL			1999	590		20	30	30	30	35
36	TOTAL (lines 4 thru 35)				$ 58,503	$ 1,716		$ 2,926	$ 1,210	$ 6,198	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MIX CEMENT			1999	4,650		20	233	233	233	9
10	FAN COIL			1999	2,685		20	134	134	134	10
11	LANDSCAPING			1999	6,417		20	321	321	321	11
12	TOILET SUPPLIES			1999	822		20	41	41	41	12
13	SPRINKLER			1999	3,381		20	169	169	169	13
14	METAL DOOR			1999	1,003		20	50	50	50	14
15	REPAIR WALK-IN REFRI			1999	2,300		20	115	115	115	15
16	INSULATION			1999	1,500		20	75	75	75	16
17	REPAIR WORK			1999	1,451		20	73	73	73	17
18	TILES			1999	1,217		20	61	61	61	18
19	LANDSCAPING			1999	1,125		20	56	56	56	19
20	CONCRETE PAD			1999	900		20	45	45	45	20
21	CTN 2X2 CHEYENE			1999	1,988		20	99	99	99	21
22	BIRCH PLYWOOD			1999	2,573		20	129	129	129	22
23	SWING DOORS			1999	944		20	47	47	47	23
24	WOOD PRODUCTS			1999	3,353		20	168	168	168	24
25	SCHLAGE LOCKS			1999	1,557		20	78	78	78	25
26	SCHLAGE LOCKS			1999	1,142		20	57	57	57	26
27	DOOR LOCKS			1999	629		20	31	31	31	27
28	REPAIR DOOR CHILLER			1999	2,900		20	145	145	145	28
29	REPAIR EXHAUSTION			1999	1,019		20	51	51	51	29
30	CHILLER			1999	850		20	43	43	43	30
31	REMOVE FAN COILS			1999	6,520		20	326	326	326	31
32	REPAIR CONTROL			1999	941		20	47	47	47	32
33	CEILING MATERIALS			1999	885		20	44	44	44	33
34	ELECTRICAL SUPPLIES			1999	1,595		20	80	80	80	34
35	CONTROL BOARD			1999	1,861		20	93	93	93	35
36	TOTAL (lines 4 thru 35)				$ 56,208	$		$ 2,811	$ 2,811	$ 2,811	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPETING			1999	630		20	32	32	32	9
10	ELECTRICAL			1999	478		20	24	24	24	10
11	HEATING & COOLING UN			1999	10,481		20	524	524	524	11
12	TILES/SLABS			1999	26,862		20	1,343	1,343	1,343	12
13	TILES/GROUT			1999	2,794		20	140	140	140	13
14	ELEVATOR REPAIRS			1999	1,448		20	72	72	72	14
15	CHILLER			1999	2,235		20	112	112	112	15
16	LIGHTING SUPPLIES			1999	1,261		20	63	63	63	16
17	AC UNIT			1999	1,650		20	83	83	83	17
18	HADN RAILINGS			1999	2,150		20	108	108	108	18
19	DOORS			1999	856		20	43	43	43	19
20	ANNEX ADDITION			1999	93,480		20	4,674	4,674	4,674	20
21	CHANDELEIR			1999	8,374		20	419	419	419	21
22	CHILLER			1999	1,450		20	73	73	73	22
23	WOOD TRIM			1999	3,639		20	182	182	182	23
24	ADD'L ELECTRICAL			1999	18,700		20	935	935	935	24
25	SPRINKLER ADDITION			1999	3,105		20	155	155	155	25
26	ADD'L ELECTRICAL			1999	2,570		20	129	129	129	26
27	SPRINKLER ADDITION			1999	4,976		20	249	249	249	27
28	MACHINE RENTAL FOR C			1999	4,529		20	226	226	226	28
29	PLYWOOD			1999	3,491		20	175	175	175	29
30	FIRE ALARM SYSTEM			1999	24,144		20	1,207	1,207	1,207	30
31	WOOD TRIM			1999	573		20	29	29	29	31
32	CALL SYSTEM			1999	1,030		20	52	52	52	32
33	AC REPAIRS			1999	1,919		20	96	96	96	33
34	WATER CHILLER			1999	29,315		20	1,466	1,466	1,466	34
35	METAL DOORS			1999	1,975		20	99	99	99	35
36	TOTAL (lines 4 thru 35)				$ 254,115	$		$ 12,710	$ 12,710	$ 12,710	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	METAL DOORS			1999	12,476		20	624	624	624	9
10	PAINTS			1999	816		20	41	41	41	10
11	ARCHITECT FEES			1999	3,369		20	168	168	168	11
12	MACHINE RENTAL FOR C			1999	1,628		20	81	81	81	12
13	ELECTRICAL			1999	3,516		20	176	176	176	13
14	GRANITE RECEPTION DE			1999	3,539		20	177	177	177	14
15	TILES/SLABS			1999	1,181		20	59	59	59	15
16	INSULATION			1999	1,500		20	75	75	75	16
17	REPAIR WORK			1999	1,500		20	75	75	75	17
18	BLINDS			1999	266		20	13	13	13	18
19	OAK RAIL			1999	3,418		20	171	171	171	19
20	GLASS & MIRROR			1999	1,160		20	58	58	58	20
21	BLINDS			1999	2,086		20	104	104	104	21
22	SWING DOORS			1999	1,172		20	59	59	59	22
23	SPRINKLER			1999	3,408		20	170	170	170	23
24	LIGHTING FIXTURES			1999	3,313		20	166	166	166	24
25	BLINDS			1999	1,746		20	87	87	87	25
26	ELECTRICAL			1999	2,500		20	125	125	125	26
27	AC REPAIRS			1999	695		20	35	35	35	27
28	OAK RAIL			1999	4,843		20	242	242	242	28
29	BLINDS			1999	4,146		20	207	207	207	29
30	FIRE EQUIPMENT			2000	17,038		20	71	71	71	30
31	FIRE DETECTION SYSTM			2000	625		20	3	3	3	31
32	BLOCK SEALER			2000	5,736		20	24	24	24	32
33	WIRING			2000	1,600		20	7	7	7	33
34	FIXTURES			2000	767		20	3	3	3	34
35	FENCE			2000	550		20	2	2	2	35
36	TOTAL (lines 4 thru 35)				$ 84,594	$		$ 3,023	$ 3,023	$ 3,023	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FIRE PROOFING			2000	1,010		20	4	4	4	9
10	MASTER BOX			2000	1,090		20	5	5	5	10
11	SPRINKLER REPAIRS			2000	1,107		20	5	5	5	11
12	CONCRETE WORK			2000	2,450		20	10	10	10	12
13	BLINDS			2000	2,474		20	10	10	10	13
14	TEST HEADER			2000	5,656		20	24	24	24	14
15	ROOF REPAIRS			2000	22,260		20	93	93	93	15
16	SPRINKLER PROJECT			2000	3,381		20	14	14	14	16
17	MICROPROCESSOR/TEMP CONTROL			2000	3,890		20	16	16	16	17
18											18
19	KELCO ELECTRIC			1996	* 14,700	735	20	735		3,001	19
20	KELCO ELECTRIC			1996	* 18,600	930	20	930		3,798	20
21											21
22	KELCO ELECTRIC			1999	* (18,500)	(925)	20	(925)		(1,850)	22
23	CONRETE FLOOR			1999	* (1,000)	(50)	20	(50)		(100)	23
24	ELEVATOR			1995	* (49,300)	(2,465)	20	(2,465)		(4,930)	24
25											25
26											26
27	* SEE ATTACHED FOR RECONCILIATION OF ITEMS										27
28	WITH AN ASTERISK										28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 7,818	$ (1,775)		$ (1,594)	$ 181	$ 100	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988	MADO	$ 55,967	$ 2,035	35	$ 1,599	$ (436)	$ 7,995	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	ALLOC-MADO MANAGEMENT			1995	1,298	303	20	65	(238)	357	10
11	ALLOC-MADO MANAGEMENT			1993	21,318	568	20	1,066	498	7,914	11
12	ALLOC-MADO MANAGEMENT			2000	4,688		20	122	122	122	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 83,271	$ 2,906		$ 2,852	$ (54)	$ 16,388	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 596,534	$ 38,910	$ 42,734	$ 3,824		$ 236,135	37
38	Current Year Purchases	25,609		256	256		256	38
39	Fully Depreciated Assets	3,100					3,100	39
40								40
41	TOTALS	$ 625,243	$ 38,910	$ 42,990	$ 4,080		$ 239,491	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	JEEP LAREDO	1995	$ 25,368	$	$	$	3	$ 18,321	42
43										43
44										44
45										45
46	TOTALS			$ 25,368	$	$	$		$ 18,321	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,730,933	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 169,367	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 216,205	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 46,838	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,396,538	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

ST. AGNES MANOR, INC.
0027870
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
ST. AGNES MANOR	129,166	6,263	12,812	6,549	32,795
1721 CORP	436,283	26,813	26,813		193,956
MADO MANAGEMENT	31,085	5,834	3,109	(2,725)	9,384
TOTALS	596,534	38,910	42,734	3,824	236,135
LINE 29: CURRENT YEAR					
ST. AGNES MANOR	23,734		197	197	197
1721 CORP					
MADO MANAGEMENT	1,875		59	59	59
TOTALS	25,609		256	256	256
LINE 30: FULLY DEPRECIATED					
ST. AGNES MANOR	3,100				3,100
1721 CORP					
MADO MANAGEMENT					
TOTALS	3,100				3,100
TOTALS (Should Tie to Totals on Page 13)					
ST. AGNES MANOR	156,000	6,263	13,009	6,746	36,092
1721 CORP	436,283	26,813	26,813		193,956
MADO MANAGEMENT	32,960	5,834	3,168	(2,666)	9,443
TOTALS	625,243	38,910	42,990	4,080	239,491

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 9,663 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 69,845	$		$ 69,845	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,435			14,435	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			109,156			109,156	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				100,024		100,024	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					82,526		82,526	13
14	TOTAL			$		$ 193,436	$ 182,550		$ 375,986	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	15,247
2	Lab and X-ray	11,158
3	Enteral Supplies	42,531
4	Equipment Rental	8,530
5	Ambulance	5,060
6		
7		
8		
9		
10		
		82,526

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1	$ 1	1
2	Cash-Patient Deposits	3,516	3,516	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,916,612	1,916,612	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,325	30,325	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,006,788	6,679,113	8
9	Other(specify): See supplemental schedule	91,679	91,679	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,048,921	$ 8,721,246	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		75,250	13
14	Buildings, at Historical Cost		424,750	14
15	Leasehold Improvements, at Historical Cos	3,372,835	3,380,128	15
16	Equipment, at Historical Cost	154,977	1,135,919	16
17	Accumulated Depreciation (book methods)	(1,540,481)	(4,220,616)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,288,774	22
23	Other(specify): See supplemental schedule		17,939	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,987,331	$ 2,102,144	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,036,252	$ 10,823,390	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,210,251	$ 2,210,251	26
27	Officer's Accounts Payable		1,075,773	27
28	Accounts Payable-Patient Deposits	34,822	34,822	28
29	Short-Term Notes Payable	5,215,423	8,203,173	29
30	Accrued Salaries Payable	55,499	55,499	30
31	Accrued Taxes Payable (excluding real estate taxes)	772	772	31
32	Accrued Real Estate Taxes(Sch.IX-B)	250,408	250,408	32
33	Accrued Interest Payable	319	319	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,767,494	$ 11,831,017	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,767,494	$ 11,831,017	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (731,242)	$ (1,007,627)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,036,252	$ 10,823,390	48

***(See instructions.)**

Facility Name & ID Number ST. AGNES MANOR, INC. **#** 0027870 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
401 K Contributions	19	19
Wage Assignments	2,199	2,199
Due from IDPA	73,371	73,371
Employee Advances	6,729	6,729
Union Dues	186	186
Accrued Replacement Tax	6,000	6,000
Deferred Maintenance	3,175	3,175
	91,679	91,679

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax -		
Non Care Property		

OTHER NON CURRENT ASSETS:		
LOAN COST-CURRENT		17,939
		17,939

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,597,650)	1
2	Restatements (describe):		2
3	**REPLACEMENT TAX AND DEPRECIATION**	186,225	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,411,425)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	680,183	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 680,183	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (731,242)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,363,251	1
2	Discounts and Allowances for all Levels	(378,867)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,984,384	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	860,430	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 860,430	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	147	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	132,867	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,720	19
20	Radiology and X-Ray	3,786	20
21	Other Medical Services	71,450	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 218,970	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	301	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 301	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	6,650	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,650	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,070,735	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,974,517	31
32	Health Care	3,155,942	32
33	General Administration	1,058,445	33
	B. Capital Expense		
34	Ownership	713,163	34
	C. Ancillary Expense		
35	Special Cost Centers	380,331	35
36	Provider Participation Fee	108,154	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,390,552	40
41	**Income before Income Taxes (line 30 minus line 40)****	680,183	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 680,183	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number	ST. AGNES MANOR, INC.	#	0027870	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(1,411,425)
Adjustments:		
		-
		-
		-
DEPRECIATION EXPENSE		(183,299)
REPLACEMENT TAX		(2,926)
Total adjustments		(186,225)
Balance - Beginning of Year		(1,597,650)
Equity(Deficit) from Page 17 Col 1		(731,242)
Related Party		
Equity(Deficit)	-467881	
Income	191496	
		(276,385)
Combined Equity - End of Year		(1,007,627)

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	PARKING INCOME	6,650
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	6,650

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,843	6,877	107,579	15.64	3
4	Licensed Practical Nurses	1,712	1,712	23,775	13.89	4
5	Nurse Aides & Orderlies	95,145	102,815	731,299	7.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,410	10,169	72,579	7.14	8
9	Activity Director	2,795	3,221	28,276	8.78	9
10	Activity Assistants	25,178	26,917	163,420	6.07	10
11	Social Service Workers	5,584	6,089	65,585	10.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,854	6,271	41,548	6.63	17
18	Housekeepers	1,942	2,006	19,022	9.48	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,834	9,482	71,923	7.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	163,297	175,559	$ 1,325,006 *	$ 7.55	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	273	$ 6,831	1-3	35
36	Medical Director	MONTHLY	2,074	9-3	36
37	Medical Records Consultant	124	5,208	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	600	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	1,935	11-3	44
45	Social Service Consultant	90	5,076	12-3	45
46	Other(specify)				46
47	DIETARY OUTSIDE LABOR		370,846	1-3	47
48	ACTIVITIES OUTSIDE LABOR		40,906	11-3	48
49	TOTAL (lines 35 - 48)	530	$ 433,476		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	62,460	$ 1,405,134	10-3	50
51	Licensed Practical Nurses	9,715	133,138	10-3	51
52	Nurse Aides	16,759	114,275	10-3	52
53	TOTAL (lines 50 - 52)	88,934	$ 1,652,547		53

STATE OF ILLINOIS

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
MGMT FEES - MADO MANAGEMENT	$ 480,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 480,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SCIENTIFIC CONTROL LAB	CONSULTATION	$ 300
MAEMAR, PC	CONSULTATION	1,425
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	1,084
WOLF & CO.	ACCOUNTING	3,319
FR&R	ACCOUNTING	21,774
PRS & ASSOCIATES	APPR. FEE FOR LOAN REN.	2,300
PETERSON APPRAISAL GROUP	APPR. FEE FOR LOAN REN.	3,500
HYNES, JOHNSON & MCNAMAR/	LEGAL	3,579
PATRICIA HOGAN	LEGAL	558
GE INFO/HDSI	COMPUTER	6,495
MID AMERICA PROGRAMMING	COMPUTER	900
* ADJ. OFF ON PAGE 5	* PRIOR PERIOD EXPENSE	435
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,669

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,849
Unemployment Compensation Insurance	18,478
FICA Taxes	98,979
Employee Health Insurance	
Employee Meals	50,523
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	3,853
401K CONTRIBUTIONS	322
TOTAL (agree to Schedule V, line 22, col.8)	$ 220,004

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	4,681
Health Care Worker Background Check	1,260
(Indicate # of checks performed 126)	
LICENSES, FEES, PERMITS	4,954
ADVERTISING AND PROMOTIONAL	6,620
ALLOC-MADO MGMT	1,813
Less: Public Relations Expense	( )
Non-allowable advertising	(6,620)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,108

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,520
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,520

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ST. AGNES MANOR, INC. # 0027870 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **71,147** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **108,153**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **50,523** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw